

No. 300
10.48

FILED JUL 2 - 1953

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21867

State File No.

BIRTH NO. REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5573 Registrar's No. 128

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Mo b. COUNTY Jackson

b. CITY (If outside corporate limits, write RURAL and give township) Independence Rural c. LENGTH OF STAY (In this place) 30 yrs

c. CITY OR TOWN Independence d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF (If not in institution, give street and city location) S. O. Bennett 10 mi east on E Truman Rd

e. STREET ADDRESS (If rural, give location) 1000 10 Mi east on East Truman Rd

3. NAME OF DECEASED
a. (First) Frank b. (Middle) B c. (Last) Sherrill

4. DATE OF DEATH (Month) (Day) (Year) June 15 1953

5. SEX Male

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct 4 1891

9. AGE (In years last birthday) 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farmer Owner

11. BIRTHPLACE (City and State or Foreign Country) Omaha Neb

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Carlton Sherrill

13b. MOTHER'S MAIDEN NAME Meta Bennett

14. NAME OF HUSBAND OR WIFE Vanetta Sherrill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes #1

16. SOCIAL SECURITY NO. ----- NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Vanetta Sherrill Independence R 3

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Bullet Wound Head
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 976X

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Jackson MO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 6-15-53

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? Self Inflicted

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Hugh A. Owens, Coroner

23b. ADDRESS 1034 Piccolo Bldg.

23c. DATE SIGNED 6-16-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 17-53

24c. NAME OF CEMETERY OR CREMATORY Buckner Hill

24d. LOCATION (City, town, or county) (State) Buckner MO

DATE REC'D BY LOCAL REG. 6-17-53

REGISTRAR'S SIGNATURE [Signature]

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Webb Funeral Home Blue Springs Mo

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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OCT 1 4 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
R B Webb

Licensed Embalmer No. *225*

P. O. Address *Blue Springs*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.